

MDR Tracking Number: M5-04-0118-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 9-8-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, office visits w/manipulations, and joint mobilization were found to be medically necessary. The therapeutic exercises, electrical stimulation, and ultrasound were found not to be medically necessary.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 9-9-02 through 12-11-02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 5th day of December 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

December 2, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured while on the job for ___ on ___. ___ saw the patient and engaged her in therapeutic activities. The carrier has not paid for these treatments from 9/9/02 through 12/11/02.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic procedures, office visits, ultrasound therapy, joint mobilization and electrical stimulation from 9/9/02 through 12/11/02.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination. The reviewer agrees with the previous adverse determination regarding billing codes 97110, 97035, and 97032.

The reviewer disagrees with the previous adverse determination regarding office visits 99211, 99211-MP, 99213, 99213-MP, 99214-MP and joint mobilization 97265.

BASIS FOR THE DECISION

This patient was injured on the job and was engaged in therapeutic activities at the recommendation of not only ____, but also _____. In reviewing the file, however, there is no indication as to what type of activities this patient performed and thus it is impossible to determine if these activities were appropriate or beneficial to the patient. Flow charts did not specify exactly what activities the patient was performing, such as treadmill, stretching, wobble boards, weights, bicycle, etc. The documentation was severely lacking and does not support medical necessity.

The reviewer recommends denial of 97110 for the following dates:

9/9/02, 9/11/02, 9/25/02, 10/7/02, 10/11/02, 10/14/02, 10/16/02, 10/18/02, 10/21/02, 10/23/03, 10/28/02, 11/4/02, 11/06/02, 11/08/02, 11/13/02, 11/15/02, 11/22/02, 12/2/02, 12/04/02, 12/06/02.

The reviewer recommends denial of 97035 for the following dates: (Passive modalities are not indicated without prior approval beyond the initial 6 weeks of care).

9/9/02, 9/11/02, 10/7/02, 10/16/02.

The reviewer recommends denial of 97032 for the following dates: (Passive modalities are not indicated without prior approval beyond the initial 6 weeks of care).

11/18/02, 11/22/02, 12/2/02, 12/11/02.

The reviewer recommends approval for billing codes 99211, 99211-MP, 99213, 99213-MP, 99214-MP on the following dates: (This doctor is the treating doctor and is required to continually assess this patient and therefore office visits are indicated.)

9/9/02, 9/11/02, 10/7/02, 10/14/02, 10/16/02, 10/16/02, 11/13/02, 11/18/02, 11/22/02, 12/2/02, 12/11/02.

The reviewer recommends joint mobilization (97265) for the following dates:

10/7/02, 10/14/02, 10/16/02, 11/22/02.

In conclusion, there was insufficient documentation of therapeutic procedures and the reviewer therefore recommends denial of those services. Additionally, passive modalities are not indicated beyond the initial six weeks of care without prior approval from the insurer. There was no documentation included which indicates that this approval was obtained, therefore ultrasound and muscle stimulation should be denied. The reviewer finds medical necessity for office visits and office visits with manipulations. This doctor is the treating doctor and is responsible for continual evaluation and treatment of the patient.

Office visits are reasonable and necessary for continuity of patient care. It is also recommended that joint mobilizations be allowed, as this procedure would be necessary for restoration of function of the injured joint, and in preventing further loss of motion.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,